North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Services Center
Raleigh NC 27699-2501

Dear Applicant,

Thank you for your interest in becoming a direct enrolled Orthotics and Prosthetics Provider with the NC Medicaid Program. A prospective provider of Medicaid services must apply and receive enrollment approval from the NC Division of Medical Assistance (DMA) to qualify for reimbursement for orthotics and prosthetics services. In order for us to complete the enrollment process, please complete the following:

- Orthotics and Prosthetics Service Provider Enrollment Application
- Medicaid Participation Agreement
- Electronic Claims Submission (ECS) Agreement – all applicants who wish to submit claims electronically must submit a signed and dated ECS agreement.
- Provider Certification for Signature on File
- W-9
- Proof of current board certification

Providers are requested to include on their application the name, e-mail address, and fax number of the individual at their site that is responsible for receiving Medicaid information.

Providers meeting all qualifications are assigned a provider number and are notified by mail once the enrollment process has been completed. Please do not submit claims for any services until you have received this notification with your provider number and its effective date. Billing information and medical coverage polices are available on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm.

Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your Orthotics and Prosthetics Provider Enrollment Specialist at 1-919-855-4050. You may also access program information on our website at http://www.dhhs.state.nc.us/dma/

Sincerely,

Orthotics and Prosthetics Provider Enrollment Specialist

North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services

Orthotics and Prosthetics Service Provider Enrollment Application For Individual

Name

Site Address (Street)

City State ZIP

Mailing Address (if different from above)

Durable Medical Equipment – Orthotics / Prosthetics Supplier Agency Name
* Business with pharmacy permit or permit from Board of Pharmacy to deliver devices and/or medical equipment

DME – Orthotics / Prosthetics Supplier Agency Medicaid Number

Type of Application
( ) Initial request
( ) Reapplication
( ) Expansion of services

Medicare number

IRS Number

Type of Provider
☐ Certified Orthotist
☐ Certified Prosthetist
☐ Certified Prosthetist/Orthotist
☐ Certified Ocularist
☐ Certified Pedorthtist
☐ Orthotics Fitter
☐ Mastectomy Fitter
☐ Fitter – Orthotics/Mastectomy

Certification Authority
☐ American Board for Certification in Orthodics and Prosthetist
☐ Board for Orthotist/Prosthetist Certification
☐ National Examining Board of Ocularists
☐ Board for Certification in Pedorthist

DMA – PROVIDER SERVICES USE ONLY!					
Provider #	**Effective Date**	**TY**	**SP**	**IRS#**	**IRS Name**
Fax #:			**Email:**		
Social Sec #		**ECS**	**SIG on File**	**License #**	**Contact Name**
		Yes No	**Yes No**		
County		**County Code**			**Group #**

A. Provider's Individual Social Security No. _____

B. EIN No. _____ **EIN Name** _____

C. Have you, or individuals or organizations having a direct or indirect ownership or control interest of five percent (5%) or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX) or Social Services Block Grant (XX)? ☐ **Yes** ☐ **No**
(If you answered 'Yes', attach explanation)

D. Have any of your directors, officers, agents or managing employees of your group been convicted of a criminal offense related to their involvement in the program of Medicaid, Medicare or Social Services Block Grant?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

E. List all shareholders/partners (including self) who have 5% or more ownership. (NOT APPLICABLE TO STATE AGENCIES)
****Please continue on additional page included ONLY if more room is needed.***

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

F. Have **<u>you</u>** or **<u>any of the individuals</u>** listed in Item 'E' ever:

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony? ☐ **Yes** ☐ **No**

If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition:

_____

_____

b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?
☐ **Yes** ☐ **No**

If 'Yes' to 'F b**', complete below and attach a copy of the final disposition. Attach documentation from the proper authorities that approve the reinstatement of the license:**

Against Whom?	Action Taken?	Who took Action?	Date of Action?

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state? ☐ **Yes** ☐ **No**

If 'Yes', list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that had suspended payments from Medicare or Medicaid in any state? ☐ **Yes** ☐ **No**

e. Owes money to Medicaid or Medicare that has not been paid? ☐ **Yes** ☐ **No**

G. Do you or any officers, directors, or owners listed in Item 'E' have ownership in any other Medicaid enrolled businesses? ☐ **Yes** ☐ **No**

If 'Yes", list other Medicaid enrolled businesses you own and the names of all owners of five percent or more of these other businesses. ***Please continue on additional page ONLY if more room is needed.***

Name of Owner	Name of Other Business	Provider Number

Signature Authorization Required

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

_____

Signature of Individual Provider or Authorized Agent **Date**

_____

Printed Name and Title of Individual Applicant or Authorized Agent

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

WE WILL NOT BE ABLE TO COMPLY IF US POSTAGE IS NOT AFFIXED.

Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501

PLACE STAMP HERE. POST OFFICE WILL NOT DELIVER WITHOUT PROPER POSTAGE.

_____
Name

_____
Address

_____
City State Zip Code

APPLICATION ACKNOWLEDGEMENT CARD

Dear Prospective Provider:

We have received your application for enrollment in the NC Medicaid Program.

DMA will notify you of your status via mail once the enrollment process has been completed, or in the event additional information is needed.

Thank you again for your interest in the NC Medicaid Program.

Sincerely,

DMA Provider Services

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

Provider Services 2501 Mail Service Center Raleigh, NC 27699-2501 Ph. 919-855-4050

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

l. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify DMA in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to DMA prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to DMA. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature), and shall ensure the claim can be associated with and identified by said source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid

recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.

8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.

9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.

l0. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.

11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.

12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.

13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.

16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

STATE USE ONLY
[ ] Initial Enrollment
[ ] Renewal
[ ] CHOW
[ ] Other Change

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
MEDICAID PARTICIPATION AGREEMENT

2501 Mail Service Center Raleigh, N.C. 27699-2501 Ph. 9l9-855-4050

_____ (_____)_____
(Business Name of Agency/Provider) (Phone No.)

_____
(Business address: Street City State Zip)

_____
(Mailing address: Street City State Zip)

_____ (_____)_____
(Name and e-mail address of contact person) (Fax No.)

A. The aforementioned provider agrees to participate in the North Carolina Medicaid Program and agrees to abide by the following terms and conditions:

1. Comply with federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement (including, but not limited to, Medicaid provider manuals and Medicaid bulletins published by the Division of Medical Assistance and/or its fiscal agent).

2. Provide services to Medicaid eligible recipients of the same quality as are provided to private paying individuals without regard to race, color, age, sex, religion, disability, or national origin.

3. Accept as payment in full, the amounts paid by the Medicaid Program except for payments from legally liable third parties and authorized cost sharing by recipients.

4. Not charge the patient or any other person for items and services covered by the Medicaid Program and to refund payments made by or on behalf of the patient for any period of time the patient is Medicaid approved, including dates for which the patient is retroactively entitled to Medicaid.

5. Maintain for a period of five (5) years from the date of service: (a) accounting records in accordance with generally accepted accounting principles and Medicaid recordkeeping requirements; and (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program. For providers who are required to submit annual cost reports, “records” include, but are not limited to, invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, etc. Such records are subject to audit and review by Federal and State representatives.

6. On request, furnish to the Division of Medical Assistance (DMA) and its agents, the Centers for Medicare and Medicaid Services (CMS), or the State Medicaid Fraud Control Unit of the Attorney General's Office, any information or records, including records of any outside entities, contractors, or subcontractors for costs related to services provided to Medicaid patients and billed to the Medicaid Program.

7. Assure that items or services provided under arrangements or contracts with outside entities and professionals meet professional standards and principles and are provided promptly. Such arrangements must include provision for access and audit of records by state and federal representatives as stated in item 6 above as are necessary to establish the amounts actually billed to and collected from the provider.

8. Determine responsibility and bill all appropriate third parties prior to billing the Medicaid Program. Upon receipt of payments from third parties subsequent to reimbursement by the Medicaid Program, promptly refund such prior payments.

9. Under penalty of perjury, inform DMA of provider tax identification name, address and number at the time of enrollment and for subsequent changes and be liable for any withholding or penalties required by IRS regulations.

B. PROVIDER FURTHER UNDERSTANDS AND AGREES:

l. Payment of claims is from State, Federal and County funds and any false claims, false statements or documents, or misrepresentation or concealment of material fact may be prosecuted by applicable State and/or Federal law.

2. DMA may withhold payment because of irregularity from whatever cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the provider and/or DMA and its agents.

3. If any part of this agreement is found to be in conflict with any Federal or State laws or regulations having equal weight of law, or if any part is placed in conflict by amendment of such laws, this agreement is so amended except that if the fulfillment of this agreement on the part of either party is rendered unfeasible or impossible, both the provider and DMA shall be discharged from further obligation under the terms of this agreement, except for equitable settlement of the respective debts up to the date of termination.

4. Neither providers nor employees thereof shall use or disclose information concerning Medicaid patients, including name and address, social and economic conditions or circumstances, medical data and medical services provided, except for purposes of rendering necessary medical care, arranging for medical care or services not available from the provider, establishing eligibility of the patient, and billing for services of the provider. Neither patient records nor portions thereof may be transferred except by written consent of the patient or as otherwise provided by law.

5. That federal and/or State officials and their contractual agents may make certification and compliance surveys, inspections, medical and professional reviews, and audit of costs and data relating to services to Medicaid patients as may be necessary under Federal and State statutes, rules and regulations. Such visits must be allowed at any time during hours of operation, including unannounced visits. All such surveys, inspections, reviews and audits will be in keeping with both legal and ethical practice governing patient confidentiality.

6. That billings and reports related to services to Medicaid patients and the cost of that care must be submitted in the format and frequency specified by DMA and/or its fiscal agent.

7. That payment will be made in accordance with the approved Medicaid State Plan.

8. Neither this agreement nor the assigned provider number shall be transferable or assignable except as provided by Federal regulations.

9. This agreement may be terminated by the Provider upon giving thirty (30) days prior written notice to all parties to the agreement.

10. DMA may terminate this agreement upon giving written notice or refuse to enter into an agreement when:

    a. The provider fails to meet conditions for participation, including licensure, certification or other terms and conditions stated in the provider agreement, or

    b. The provider is determined to have violated Medicaid rules or regulations, or

    c. Any person with ownership or control interest in the provider agency or an agent or managing employee of the provider has been convicted of a criminal offense related to services provided under titles XVIII, XIX, or XX of the Social Security Act, or

    d. The provider fails to provide medically appropriate health care services, or

    e. The State determines it to be in the best interests of the State and Medicaid recipients to do so.

11. Claims may not be reassigned to an individual or organization that advances money to the provider of services for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

C. AS A PROVIDER OF ORTHOTICS AND PROSTHETICS SERVICES, THE PROVIDER AGREES TO COMPLY WITH THE FOLLOWING CONDITIONS:

1. Provider is board certified by one of the following entities:
    a. The American Board for Certification in Orthotics and Prosthetics
    b. Board for Orthotist/Prosthetist Certification
    c. Board for Certification in Pedorthotics
    d. The National Examining Board of Ocularists, Inc.

2. Provider cannot accept prescriptions for Medicaid-covered equipment from any physician, physician assistant or nurse practitioner or practitioner who has an ownership interest in their agency.

3. Devices and/or medical equipment are supplied under a written order or plan of care as medically necessary devices. The written prescription, Certificate of Medical Necessity and Prior Approval form must be retained in the recipient's record at the dispensing location and kept confidential and secure.

4. Provider must be an approved and actively enrolled in Medicare as an Orthotics and Prosthetics services provider.

5. Provider must be located within the boundaries of North Carolina or within 40 miles of the North Carolina border to serve North Carolina recipients living near the border.

6. The provider of services shall be obligated to furnish all necessary maintenance services on devices and medical equipment as required by DMA policies, procedures, and regulatory mandates.

7. Provider is responsible for replacement or repair of devices and/or medical equipment or any part thereof that is found to be non-functional because of faulty material or workmanship within the guarantee of the manufacturer, without charge to the recipient or the Medicaid program.

8. Devices and/or medical equipment purchased by the Medicaid Program become the property of the Medicaid recipient.

9. Provider agrees to file an amended application with DMA within 30 calendar days of a change in name, ownership or controlling interest, IRS or Medicare numbers.

D. ELECTRONIC CLAIMS SUBMISSION:

The provider attests that they have read the conditions defined for submission of electronic claims contained in the enclosed Electronic Claims Agreement and hereby elect to:

[ ] Submit claims electronically and to abide by the conditions for electronic submission agreement.

[ ] Not submit claims electronically at this time*****.
*****_The provider understands that a separate agreement for electronic claims must be signed and approved if they subsequently elect to file claims electronically_.

E. SIGNATURE OF PROVIDER IS REQUIRED:

_____
Signature of Individual Provider OR Authorized Agent **Date**

_____
Printed Name of Provider OR Authorized Agent

_____ _____
Business Name on W-9 **IRS or EIN Number**

THIS SECTION IS FOR INTERNAL USE ONLY BY THE DIVISION OF MEDICAL ASSISTANCE.

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided.

DMA APPROVAL:

Accepted on _____ by _____.

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____

Print or Type Business Name of Provider

_____

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____